Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005037	A. BUILDING: _____ B. WING _____	C 04/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMERON MEMORIAL COMMUNITY HOSPITAL INC	416 E MAUMEE ST ANGOLA, IN 46703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The visit was for investigation of a State hospital complaint. Complaint Number: IN 00125062 Unsubstantiated: lack of sufficient evidence Date: 4-02-13 Facility Number: 005037 Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor Cameron Memorial Community Hospital is in compliance with 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules. QA: claughlin 04/26/13	S 000		